price of which the manufacturer is aware.

(B) The audit findings or investigation related to the average manufacturer price and best price have not been resolved.

(2) [Reserved]

(i) *Timeframe for reporting revised average manufacturer price or best price.* A manufacturer must report to CMS revisions to average manufacturer price or best price for a period not to exceed 12 quarters from the quarter in which the data were due.

[68 FR 51917, Aug. 29, 2003, as amended at 69 FR 513, Jan. 6, 2004; 69 FR 68818, Nov. 26, 2004]

§§ 447.536–447.550 [Reserved]

PART 455—PROGRAM INTEGRITY: MEDICAID

Sec.

Subpart A—Medicaid Agency Fraud Detection and Investigation Program

Subpart B—Disclosure of Information by Providers and Fiscal Agents

AUTHORITY: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

SOURCE: 43 FR 45262, Sept. 29, 1978, unless otherwise noted.

§ 455.1 Basis and scope.

This part sets forth requirements for a State fraud detection and investigation program, and for disclosure of information on ownership and control.

(a) Under the authority of sections 1902(a)(4), 1903(i)(2), and 1909 of the Social Security Act, Subpart A provides State plan requirements for the identification, investigation, and referral of suspected fraud and abuse cases. In addition, the subpart requires that the State—

(1) Report fraud and abuse information to the Department; and

(2) Have a method to verify whether services reimbursed by Medicaid were actually furnished to recipients.

(b) Subpart B implements sections 1124, 1126, 1902(a)(36), 1903(i)(2), and 1903(n) of the Act. It requires that providers and fiscal agents must agree to disclose ownership and control information to the Medicaid State agency.

[51 FR 34787, Sept. 30, 1986]

§ 455.2 Definitions.

As used in this part unless the context indicates otherwise—

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

Conviction or *Convicted* means that a judgment of conviction has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending.

Exclusion means that items or services furnished by a specific provider who has defrauded or abused the Medicaid program will not be reimbursed under Medicaid.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other